

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

**REMODULIN (treprostinil)**

Patient name: \_\_\_\_\_ Medicaid or SS# \_\_\_\_\_

Physician Name: \_\_\_\_\_ Contact person: \_\_\_\_\_

Phone#: \_\_\_\_\_ Ext. and opt. \_\_\_\_\_ Fax# \_\_\_\_\_

Pharmacy \_\_\_\_\_ Pharmacy Phone#: \_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

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**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF  
MEDICAL NECESSITY**

**CRITERIA:**

- ▶ Documented diagnosis of Primary Pulmonary Hypertension

**AUTHORIZATION:**

1 year

**RE-AUTHORIZATION:**

Telephone call from physician office or pharmacy